PULSE REPORT

2009

Safety Culture

Staff Perspectives on American Health Care

PRESS GANEY®

Executive Summary

Patient safety remains one of the biggest challenges for health care providers. Studies show that more than 2 million patients are injured unnecessarily in hospitals every year, with more than 100,000 people dying as a result. Medication errors in hospitals alone cost at least $3.5 billion annually to treat, the Institute of Medicine has found. In response, many hospitals and physician offices have adopted a number of high-tech interventions, including electronic medical records, medication bar coding and computerized physician order entry systems. Providers have also adopted checklists for patient handoffs to avoid errors and other protocols for common procedures such as central line placement, to avert introduction of nosocomial infections. Each of these advances has had a positive impact, and yet data show that the problem of preventable medical errors continues to plague the U.S. health care system.

A small but rapidly growing number of providers are trying out a low-tech, low-cost solution for patient safety—adopting a culture of safety. Such a culture involves an organization-wide commitment to safe care. That starts with a data-based assessment of the current safety culture, including surveys of front-line caregivers and administrators on perceptions of the commitment to safety. From that data, a coherent and cogent plan for improvement is adopted, including unit-specific action plans. Clearly set expectations and definitions of safe behavior help to cultivate shared values and beliefs that are consistent with the overall organizational approach to safety. What flows from these actions is, at its best, continuous quality improvement.

Increasingly, actions by federal and state governments and the private sector are underscoring the need for a safety culture. The federal Centers for Medicare and Medicaid Services and private insurers have established lists of preventable medical errors for which reimbursement is now denied. And the Joint Commission has mandated that health care facilities assess their culture of safety on a regular basis with a valid and reliable tool.

Against this backdrop, the *2009 Safety Culture Pulse Report*—the first of its kind—establishes a baseline for future improvement efforts. The data are derived from Press Ganey Safety Culture Assessment results obtained at 75 health care facilities across the U.S. from Jan. 1 to Dec. 31, 2008, and represent the experiences of 42,378 employees who were given the opportunity to report their perceptions of their facilities' practices that affect patient safety.

This report finds that communication—or its absence—is at the root of many of the issues surrounding patient safety, and presents the greatest opportunity for improvement. There is also a staggering disconnect on views of patient safety between administration and front-line caregivers—administrators tend to have a far sunnier view of safety than registered nurses and physicians in training.

Of the thirteen dimensions of patient safety culture addressed in the Safety Culture Assessment, the two that are most often represented as priorities are:

- **Hospital/Management Support**
- **Feedback/Communication About Error**

These findings are part of a series of Press Ganey Pulse Reports and Check-up Reports being released throughout 2009. These reports examine the status of health care quality across different care settings and from different perspectives. These findings and observations highlight the progress being made in the face of today's challenging health care landscape, call for some needed change, and explore the path to improving the quality of American health care.

Contents

Top Opportunities
for Improving Safety Culture

Press Ganey's National Safety Culture Priority Index highlights the greatest opportunities for organizations to improve their safety culture. Focusing on these items, with particular emphasis on addressing the top priorities, will help organizations make notable improvements in patient safety.

A need for greater focus on communication and coordination—from hospital management and between hospital units and front-line care providers—is the main theme reflected in the top five opportunities. Organizations with a positive safety culture have leaders who effectively communicate patient safety priorities and efforts of the organization through consistent messages and priorities, as well as open communications across the organization. This communication and transparency helps to establish organizational trust and collective perceptions of the importance of safety and the value of integrated preventive measures.

National Safety Culture Priority Index

Survey Items are correlated to employee ratings of "Overall Safety Rating"
Represents the experiences of 42,378 employees across 75 hospitals/facilities nationwide between January 1 and December 31, 2008

Survey Item	Priority Rank
Hospital management seems interested in patient safety only after an adverse event happens	1
Staff feel free to question the decisions or actions of those with more authority	2
We work in crisis mode trying to do too much, too quickly	3
We are given feedback about changes put into place based on event reports	4
Hospital units do not coordinate well with each other	5
When an event is reported, it feels like the person is being written up, not the problem	6
In this unit, we discuss ways to prevent errors from happening again	7
My supervisor/manager seriously considers staff suggestions for improving patient safety	8
The actions of hospital management show that patient safety is a top priority	9
We have patient safety problems in this unit	10
Hospital management provides a work climate that promotes patient safety	10

Staff Insight

Comments by health care workers on surveys allow for deeper understanding of their perceptions and add depth and focus to quantitative data, ensuring critical opportunities for improvement are not missed. Each section of the *2009 Safety Culture Pulse Report* includes representative comments from health care workers on the topic of that section.

" Events are often appropriately noted and reported on the unit, but there is zero feedback or follow-up of which we are aware. It feels like a black box ... so what's the point?"

" The only thing that I think our hospital could improve on is cooperation between departments. Sometimes turf' issues prevent constructive feedback between departments from being received well. I think that each unit sometimes gets tunnel vision and does not see things from the perspective of other units. Improved communication could help this."

Press Ganey Guidance

Española Hospital, Española, New Mexico

Española Hospital is an 80-bed general and acute care hospital located in Española, New Mexico.

Following the completion of Press Ganey's Safety Culture Assessment, the hospital decided to increase hospital-wide error communication upon a recommendation from its Press Ganey Safety Culture Consultant to create a more straightforward approach with timely, accurate, complete, and clear feedback regarding changes. The Consultant also suggested regular communication with staff such as weekly sessions with team members to update staff on relevant news and changes, or brief meetings at the beginning or end of each nursing shift to discuss possible safety concerns.

As a result, a new error reporting system that guaranteed anonymity for the person reporting was implemented. Each error report is reviewed and then referred to the appropriate manager for further investigation and follow-up. Before the new system, errors had been kept in confidence, but now the hospital believes that errors must be shared along with their cause, according to Brenda Romera, Española's chief nursing officer. She says that the important element is not the process but the conversations with staff, engaging their thought process related to patient safety and letting them feel that their concerns are heard. Romera often goes out of her way to thank her staff for keeping patient safety in the forefront of their minds.

As a result of these efforts, the question, "We are given feedback about changes put into place based on event reports," dropped from No. 1 to No. 20 on the hospital's Safety Culture Priority Index, indicating an improved safety score.

Dimensions of *Safety Culture*

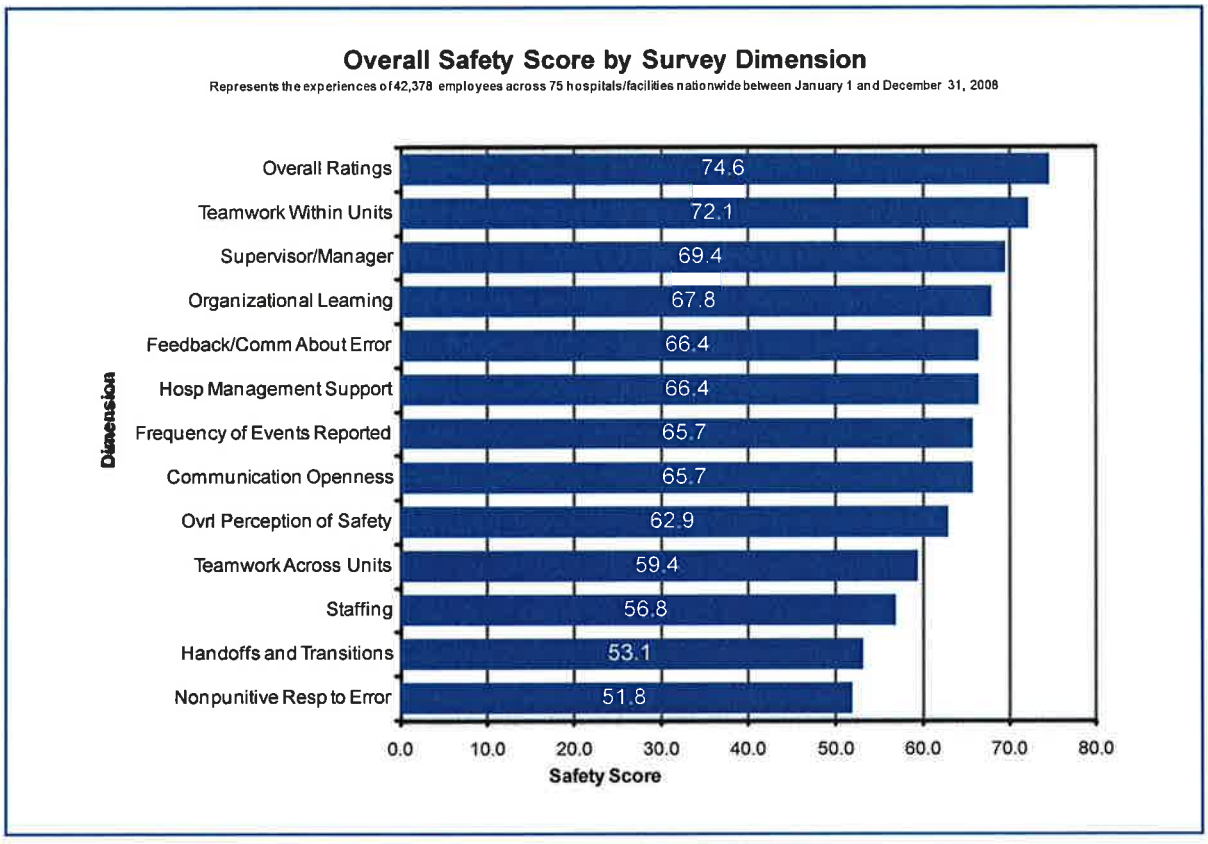
Thirteen dimensions of safety culture are addressed in the Press Ganey Safety Culture Assessment:

- Overall perceptions of safety
- Supervisor/manager expectations and actions promoting safety
- Feedback and communication about error
- Staffing
- Hospital handoffs and transitions
- Overall ratings
- Frequency of events reported
- Teamwork within units
- Non-punitive response to error
- Teamwork across hospital units
- Communication openness

Dimensions represent various aspects that affect staff perceptions of organizational safety culture, including communication regarding patient safety and medical errors, the effectiveness of safety procedures and systems, and coordination among staff.

Of these dimensions, non-punitive response to error and handoffs and transitions represents the areas of greatest opportunity for improvement. Questions relating to these dimensions address staff members' perceptions of whether or not they will be held personally responsible for mistakes or errors that occur, and the communication of information at critical junctures in patient care.

A system-focused, non-punitive culture builds programs that strive for comprehensive management programs and include the person, the team, the task, the workplace, and the institution as a whole. The systems approach concentrates on the conditions under which individuals work and builds defenses to avert errors, or mitigate their effects. This is an important mindset for health care organizations to adopt as it leads to a non-punitive environment in which errors are reported freely, caregivers speak up, and patient safety is improved.



Staff Insight

- *"It appears that we have too many projects going on at the same time and not enough time to bring them to completion. The thought of just culture is important and is something that we need to reinforce with staff to remove the element of blame."*
- *"Errors are reported much more readily since they are no longer held against the employee. We learn from our mistakes and do things to prevent recurrence of same or similar events."*
- *"Feel there is a need for better rapport and teamwork with other nursing units. This facility has a 'it's not my job' attitude when transferring patients from units."*
- *"Various departments are very compartmentalized and no one wants to take responsibility. Often times, one department tries to 'dump' on another department. Communication is often lacking. Some departments are so interested in handing off their patients quickly that key information is not always shared."*
- *"I think overall safety is a topic employees keep in the front and foremost of their minds. I would say only two concerns—communication from shift change is not always thorough, and communication between departments when patients are being transferred is not thorough."*
- *"It seems like all event reporting are treated very confidential, unless we have a death—then it is a big discussion. I think we should all share our mistakes to learn from them."*

Press Ganey Guidance

Hennepin County Medical Center, Minneapolis, Minnesota

Hennepin County Medical Center is an academic medical center and public hospital located in downtown Minneapolis. After completing the Press Ganey Safety Culture Assessment, the organization identified a need to encourage more open communication with regard to staff members' reporting of errors and patient safety concerns. The hospital's Press Ganey Safety Culture Consultant suggested that when an error did occur, leadership should disseminate pertinent information to all involved, and that anyone who could assist in the effort to prevent similar events in the future be included in the discovery process and generation of solutions.

Following this advice, Hennepin implemented "Safety Chats." The chats take place approximately two to three times per month on both inpatient and outpatient units. A team consisting of the hospital's CEO, its executive leadership team, chief of staff, patient safety officer, and associate medical director of performance measurement and improvement meets with front-line staff to ask open-ended questions such as, "Do you have any concerns about safety?", "Is there anything that we can do system-wide to improve safety?" and, "Is there anything that we can do at the unit level to improve safety?" Hennepin's patient safety officer brings issues of high importance to the organization's Interdisciplinary Quality Committee and asks the committee to pursue improvement. Another member of the team keeps tabs on the improvement initiative, asks for updates, ensures action plans are put in place, and places a bi-monthly summary in the hospital's newsletter to ensure staff members know what improvements are being made and the status of each improvement project.

As a result, Hennepin made statistically significant improvements in ten of the thirteen safety culture dimensions, with non-punitive response to error ranking highest. Additionally, two of the three questions within the hospital management support dimension improved and are no longer ranked as one of the hospital's top ten priorities.

Perceptions
by Staff Position

Many different factors can affect staff member perceptions of the safety culture within an organization. Front-line staff, physicians, and administration have been found to hold very different views of safety. Nationwide, administration/management has, by a wide margin, the highest regard for their organizations' safety culture. By contrast, nurses and resident physicians' view the culture of their organizations far differently.

Graph Key Examples:

Administration/management: Nurse manager, nursing supervisor, pharmacy manager, administrative manager, health care executive

Unit assistant: Office specialist, medical secretary, stock clerk, patient services coordinator

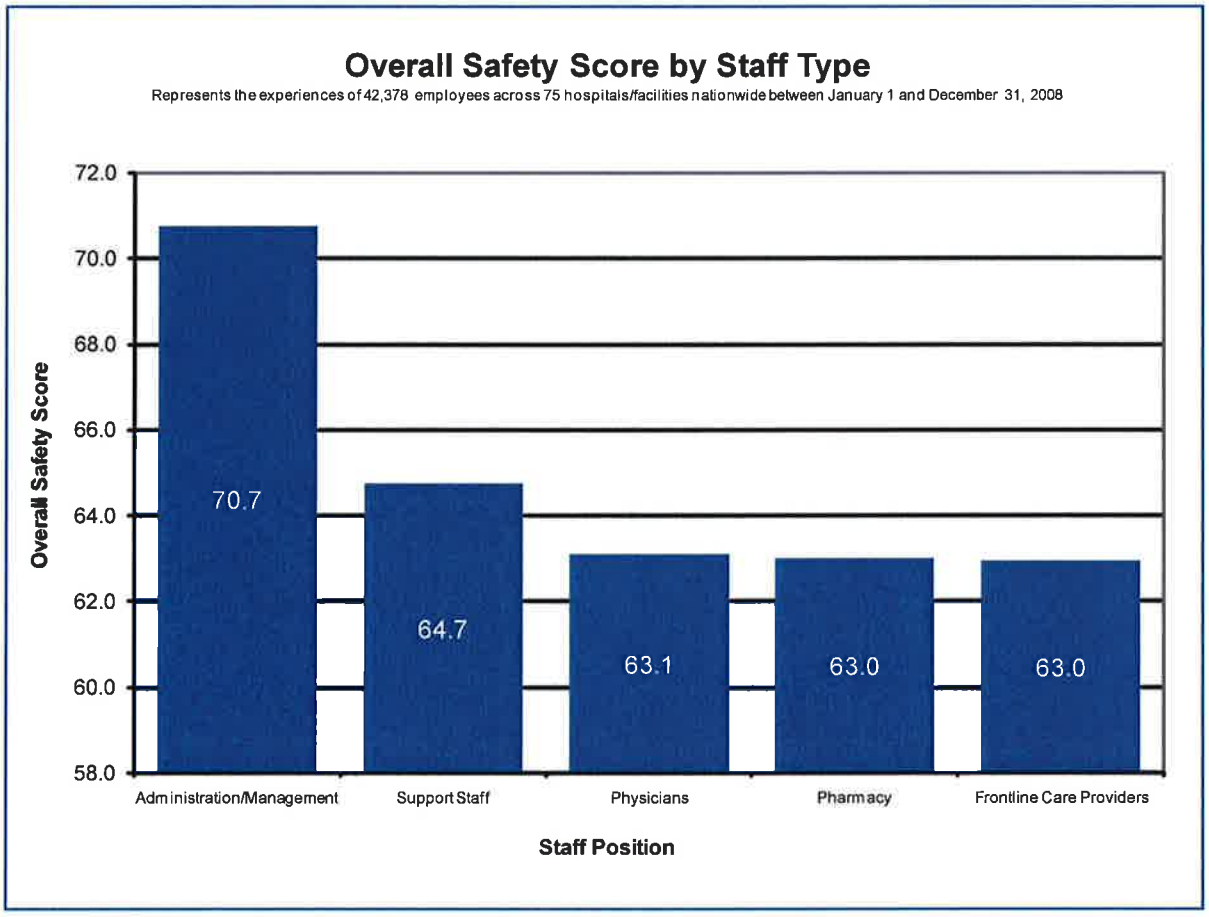
Patient care assistant: Health care assistant, dental assistant, health care specialist, medical assistant, nursing assistant, public service assistant

Technician: Lab assistant, ultrasound tech, radiology supervisor, surgical tech, med lab tech, pharmacy tech

Other: Mental health worker, case management assistant, public services assistant, chaplain, interpreter

Physician assistant/nurse practitioner: Nurse practitioner, nurse anesthetist, neonatal nurse practitioner, psychologist, nursing clinical specialist, dental hygienist

When grouped by staff type, we see the largest disconnect between administrators and front-line staff members —those who provide direct care to patients. Engaging the front-line staff in daily efforts to improve patient safety is critical to success. If staff members are able to follow the process of identifying problems, formulating solutions, and selecting and implementing improvement plans, they will be more committed to the effort. Front-line involvement fosters an organization-wide culture change that makes patient safety a recognized daily priority.



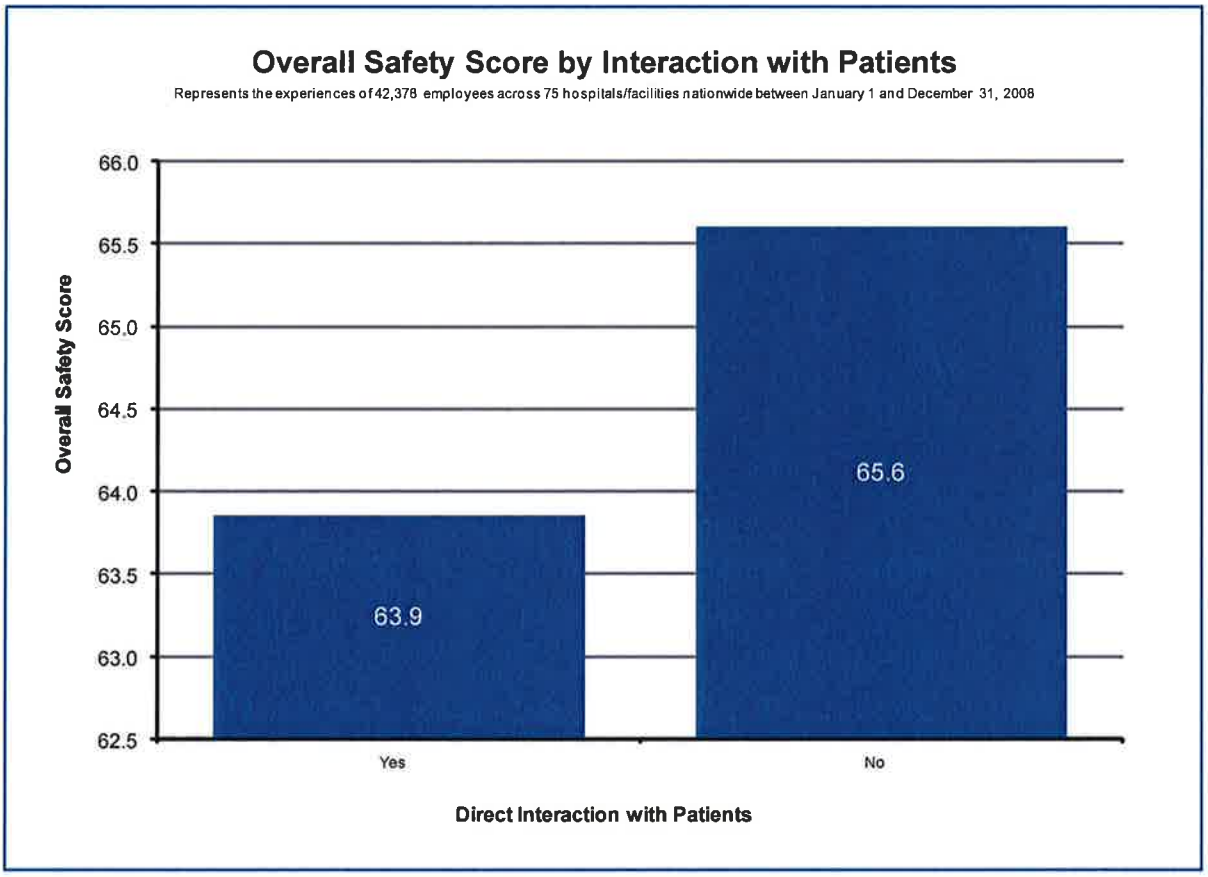
Staff Insight

" *Safety is important; however, I am concerned as to how dedicated senior management will be to following through on recommendations, versus how much recommendations will be watered-down to make life easier.*"

" *While we are making progress in improving patient safety, I am concerned that we are not pushing hard enough from top to bottom.*"

Perceptions
by Level of Involvement with Patients

Staff members who have direct interaction with patients view the safety culture of their organization in a more negative light than those who don't have face-to-face contact.



Overall, the differing perceptions on safety may be attributable to differing access to information, motivational bias, and/or communication gaps, which not only affect the development of a culture but also undermine the implementation of safety efforts. To close these gaps, organizations must develop a culture that promotes patient safety with an organization-wide commitment to identifying, acknowledging, addressing, and reconciling these differences among all members of the organization.

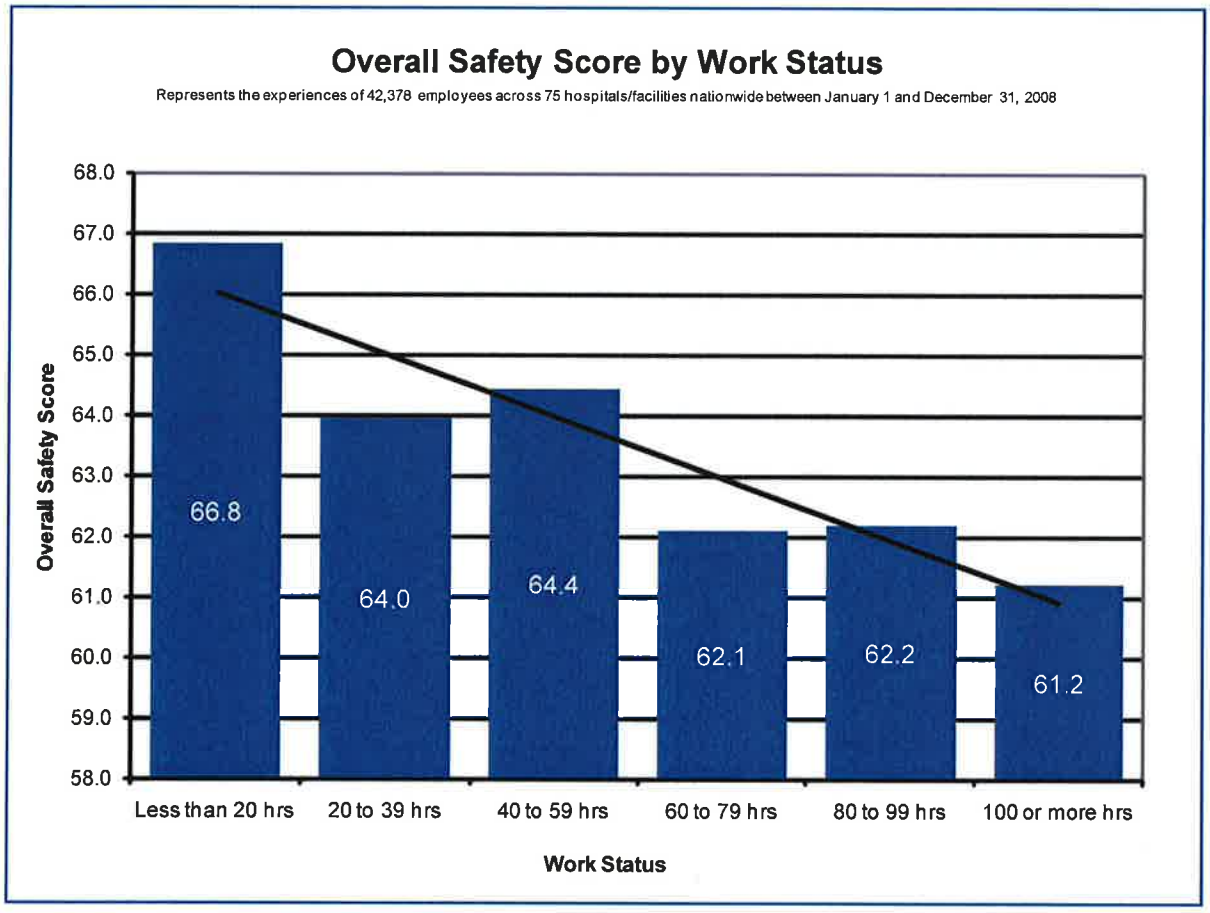
Staff Insight

" People on the front lines hear the concerns and complaints of patients daily, all day long."

" I feel that management doesn't listen to the nurses' input regarding patients' safety unless events happen, then most of the blame is given to the nurses. They make changes without consulting people who do direct patient care."

Perceptions
by Number of Weekly Hours Worked

Part-time employees view the overall safety culture of an organization more positively than full-time employees. This linear relationship between number of hours worked and overall safety score may be due, in part, to the fact that staff members who work longer hours are exposed to more adverse events or near-misses.



Staff Insight

" Nurses are allowed to work as many as twelve, eight to twelve hour, night shifts in a row. This is not acceptable for patient safety."

" It is difficult to provide safe, effective care if you need to stay hours after your scheduled shift has ended."

" Staff do too many double shifts in one week and this causes safety issues."

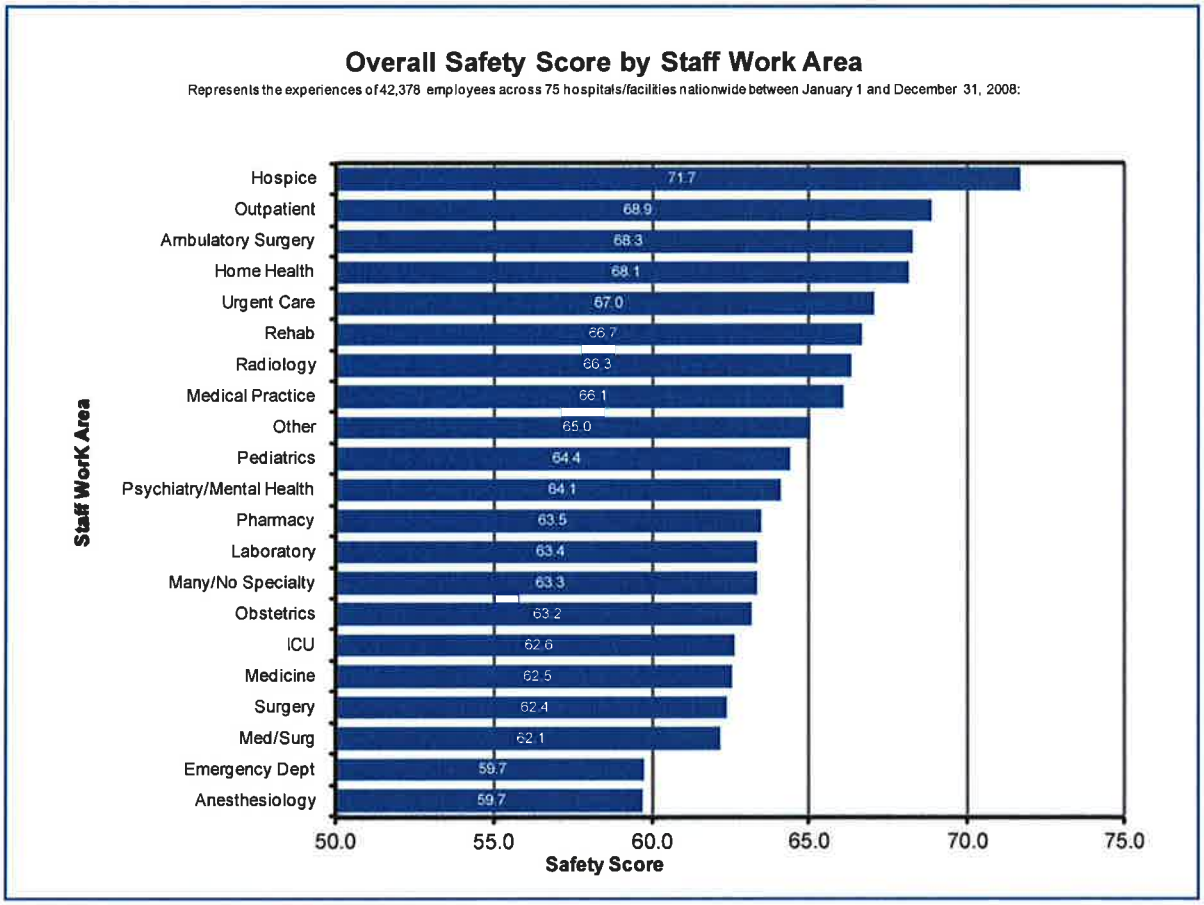
" Twelve hour shifts back to back can lead to nurse fatigue and can contribute to errors."

Perceptions *by Work Area*

Of the 21 work areas represented, those with the most complex patient-to-staff and staff-to-staff interactions and procedures—areas such as surgery, medical/surgical, emergency department, and anesthesiology—report the lowest perceptions of safety culture.

These complex work areas require far more patient handoffs and transitions between staff, shift, and areas as well as deeper communication intricacies—all factors that may contribute to the likelihood of increased errors and reduced patient safety.

Organizations will benefit by reviewing the current policies and protocols in these work areas to determine which factors have the greatest influence on patient safety and the culture of safety in order to break down barriers and decrease the likelihood of medical errors.



Graph Key Examples:

Other: Housekeeping, food/nutrition, volunteer services, admissions, environmental services, dietary

Medicine: This non-surgical designation encompasses units providing comprehensive care managing both common and complex illnesses.

Many/no specialty: Staff or physicians who "float" or work on various units throughout the hospital (e.g., care coordinator, float pool, clinical educator, interpreters, social services, residents, medical staff)

Staff Insight

" I think that most staff and management feel that patient safety is a top priority. However, in the ED, patient load and acuity change constantly and are unpredictable. When we are adequately staffed, patient safety remains #1. Many times, we try to get too much done too quickly in order to move patients through, and patient safety is, at times, not foremost on our minds."

Press Ganey Guidance

Hospital for Special Surgery, a 162-licensed-bed orthopedic hospital in New York City, is nationally ranked No. 1 in orthopedics and No. 4 in rheumatology by *U.S. News & World Report*. It has received Magnet recognition for excellence in nursing, was rated the No. 1 knee-hip orthopedic hospital in AARP's *Modern Maturity* magazine, and was the first recipient of the New York State Health Department's Patient Safety Award in 2002. Despite these accomplishments, hospital officials recognized the need to improve patient safety.

HSS initially conducted an internally developed survey to assess its culture of safety, but wanted to go a step further and have the ability to benchmark its data with other institutions. Hospital leaders decided it was time to change course and implemented the Press Ganey Safety Culture Solution. Assessment results identified that key areas of opportunity fell within the non-punitive response to error, feedback/communication about error, and hospital management support dimensions. "We deliberately focused our actions so that we would be able to accomplish our goals," indicated Gayle White, director of Standards and Accreditation.

After taking a methodical approach to disseminating the results across the organization, and ensuring information was shared with staff across all units and work areas, the hospital began conducting focus groups to further understand issues surrounding the identified dimensions. "Focus groups are a bridge from information obtained in the survey to understanding and developing new initiatives," White said.

Each of the nine focus groups had eight to ten staff members who were selected randomly based on their positions within the hospital. A trained facilitator guided them through such questions as:

- What does a culture of safety mean to you?
- What are some of the major concerns you have about reporting something that is unsafe?
- How do you receive information about a safety issue?
- What do you think would happen to someone else if they reported a mistake?
- Is there anything else you want to tell us about the culture of safety in this hospital?

"One word of advice for focus groups is it's important to be prepared to deal with the results or feedback that you might receive. With the backing of our CEO, we determined that yes, we were ready," said Marion Hare, vice president of Operations.

Concepts from the focus groups were grouped into categories, and then analyzed for common themes. After staff validated the focus group results, Hare and White met with the hospital's steering committee and facilitators to discuss and brainstorm next steps, working to narrow the focus for hospital-wide initiatives. As a result, three new initiatives have been started at HSS: Patient Safety Leadership WalkRounds, development of a surgical safety checklist, and the implementation of an electronic reporting tool for good catches and incidents. Additionally, the interdepartmental culture of safety task force has been working to further identify the barriers of patient safety by recruiting input from staff who work in multiple areas of the hospital and across varying specialties.

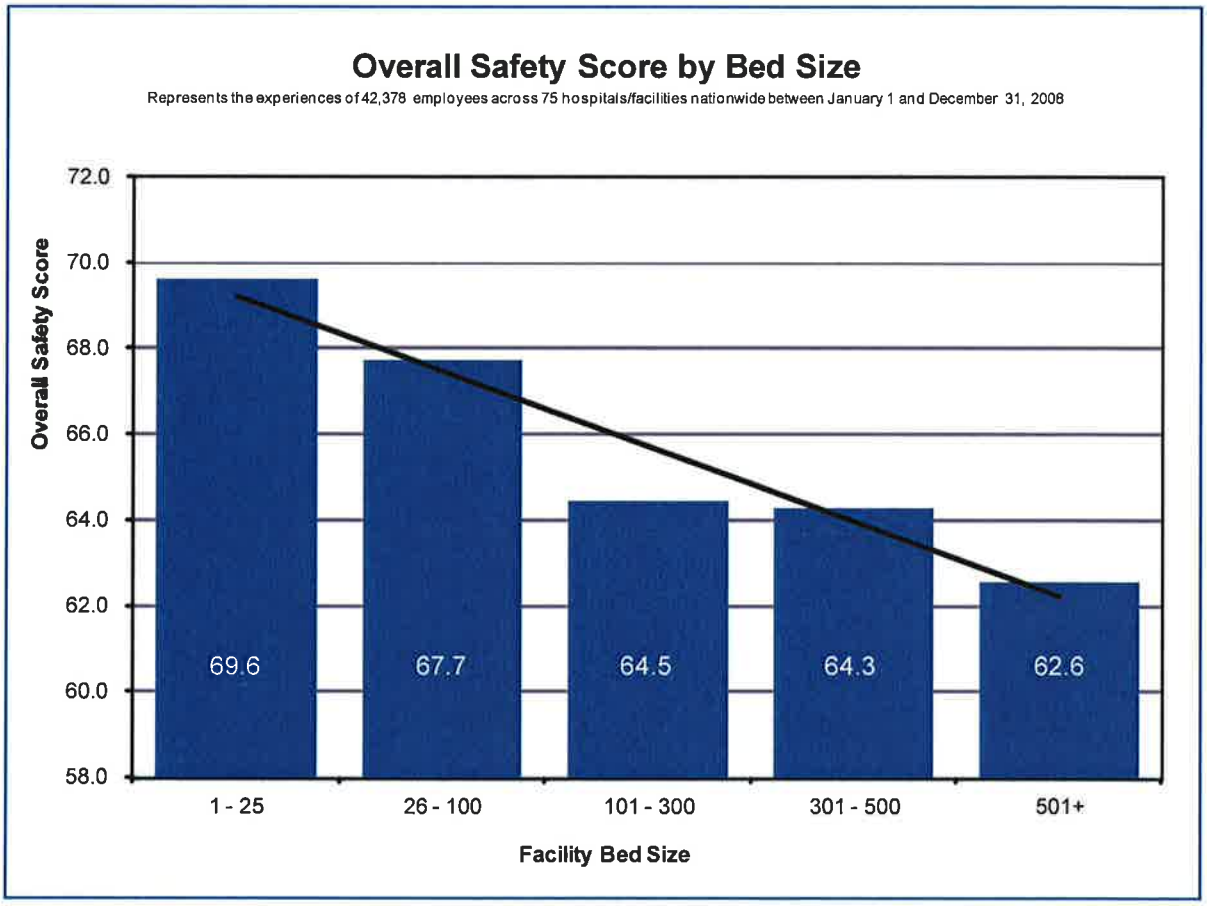
"In the focus groups, we were able to break down what was going wrong, what areas we could change, and what new ideas we could bring to light in the different departments," stated Damon Argento, a physician assistant mentor for the hospital." The results have been a catalyst to take our culture of safety to the next level. I can't wait to see our results the second time around because we've put a lot of effort into the culture of safety over the past year."

Hospital for Special Surgery understands that cultural change will not happen overnight, but they are improving safety one employee and department at a time and remain optimistic about keeping the momentum for patient safety.

Perceptions
by Hospital Size

The larger the organization, the lower the overall perception of safety culture. This linear relationship between overall safety rating and facility bed size may be due, in part, to communication complexity, added likelihood of cultural variety amid units and work areas, and a greater number of critical junctions in patient care as hospital size increases.

Already a significant challenge across organizations of all sizes, larger health care organizations have the added responsibility of greater communication efforts. Engaging all staff throughout an organization is a key component to improving safety culture. For large scale improvements and cultural changes to succeed, it is essential for staff throughout the organization to be aware of the activities and efforts being made to improve patient safety and to take active part in those initiatives. While leadership sets the example and tone, each person contributes to the overall success of the organization. Limiting the data only to management or administrators greatly reduces its effectiveness in stimulating improvements.



Staff Insight

" Things do fall between the cracks. The larger our hospital gets, the more difficult effective communication gets."

Press Ganey Guidance

University Medical Center, Lubbock, Texas

University Medical Center in Lubbock, Texas (UMC) is the primary teaching hospital for the Texas Tech University Health Sciences Center. Following the implementation of Press Ganey's Safety Culture Assessment, UMC, identified the need for a deeper integration of improvement efforts hospital-wide.

As a result, the hospital developed a safety coach program, consisting of front-line staff, designed to promote open communication, teamwork, and error reporting. The goal of safety coaches is twofold. First, they instruct colleagues on safety issues and take the lead in preventing errors—to resolve any immediate danger as soon as they spot a safety issue; and second, they serve as the eyes of the administration and take note of incidents and observations to be discussed at the safety coaches' monthly meeting. The safety coaches serve as trusted and valuable resources for administrators and colleagues alike, and often share their experiences in dealing with safety issues as a training tool for the team.

The program provides a daily connection between front-line care providers and the organization's efforts, and has resulted in a number of process improvements including a change in medication packaging where labels were difficult to read and could have resulted in medication error and the elimination of transfers within the hospital during shift changes. As UMC continues to develop its culture of patient safety, front-line staff will continue to be a valuable component.

"I think the advantage of focusing our efforts on safety culture versus other safety initiatives is that it brings to light the idea that bad things can happen within one's organization, even though we don't intend for those things to happen," said Jeff Hill, division director of Support Services for UMC. "Unfortunately, I think what happens is oftentimes, because there's fear or anxiety about discussing (medical mistakes), we tend to not discuss them. And so, what the patient safety culture does is allow us to remove some of those barriers that exist so that things that happen within an organization can be discussed—not in a punitive way—but in a positive way to affect positive change for future patients."